

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 9 9 — 0 1 3	2. STATE: MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 1999	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.300-321	7. FEDERAL BUDGET IMPACT: a. FFY 2000 \$ (4,000)* in thousands b. FFY 2001 \$ 1,500 in thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B(1)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same

10. SUBJECT OF AMENDMENT:
Acute Hospital Outpatient Payment System

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☒ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Not required under 42 CFR 430.12(b)(2)(i)
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Mark E. Reynolds</i>	16. RETURN TO: Bridget Landers Coordinator for State Plans Division of Medical Assistance 600 Washington Street Boston, MA 02111
13. TYPED NAME: Mark E. Reynolds	
14. TITLE: Acting Commissioner	
15. DATE SUBMITTED: December 30, 1999	

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17. DATE RECEIVED: December 30, 1999	18. DATE APPROVED: June 6, 2001
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 1999	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Ronald Preston</i>
21. TYPED NAME: Ronald Preston	22. TITLE: Associate Regional Administrator for Medicaid and State Operations
23. REMARKS:	

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**Methods Used to Determine Rates of Payment for
Acute Outpatient Hospital Services**

I: OVERVIEW

On August 7, 1998, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the MassHealth program's seventh Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as MassHealth providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing MassHealth members with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/ surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; and (4) currently utilize more than 50% of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA. All eligible acute hospitals are participating providers.

The RFA was effective October 1, 1998 was amended on July 1, 1999 to implement the second phase of Ambulatory Patient Groups (APGs) and on October 1, 1999 to include an update of 1.43% to the Ambulatory Patient Groups (APGs) Conversion Factors, and several definition revisions

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II: DEFINITIONS

Ambulatory Patient Group (APG) - A group of outpatient services that have been bundled for purposes of categorizing and measuring casemix and setting rates. It is based on the 3M Corporation's APG version 2.0.

APG Outlier Payment. A payment made to hospitals in addition to an APG payment rate to compensate hospitals for visits that require extraordinary utilization of resources.

Clinical Laboratory Service - Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Community Based Entity - Any entity which is not a hospital-based entity.

Community-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

Contract (Hospital Contract or Agreement) - The agreement executed between each selected hospital and the Division.

Contractor - Each hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.

Division - The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Division of Medical Assistance.

Division of Health Care Finance and Policy (DHCFP) - a Division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services created pursuant to G.L. c.118G. DHCFP performs many of the functions performed by the former Rate Setting Commission and former Division of Medical Security.

Emergency Department (E.D.) - A hospital's Emergency Room or Level I Trauma Center which is located at the same site as the hospital's inpatient department.

Emergency Medical Condition - A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average

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knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services - Covered inpatient and outpatient services, including Behavioral Health Services, that are furnished to a member by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize a member's emergency medical condition.

Hospital – (also referred to as acute inpatient hospital) Any hospital licensed under M.G.L. c. 111, §51 which meets the eligibility criteria set forth in Section 1 of Attachment 4.19B (1) of this State Plan.

Hospital-Based Entity - Any entity which contracts with a hospital to provide medical services to members, on the same site as the hospital's inpatient facility or hospital-licensed health center, for the hospital's outpatient department, emergency department or hospital-licensed health center.

Hospital-Based Physician - Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide services to members, on the same site as the hospital's inpatient facility or hospital-licensed health center, for the hospital's outpatient department, emergency department or hospital-licensed health center. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, and physician assistants are not hospital-based physicians.

Hospital-Licensed Health Center (HLHC) - A facility which is not physically attached to the hospital that (1) operates under the hospital's license; (2) meets the Division's requirements for reimbursement as a HLHC as provided at 130 CMR 410.413; (3) is approved by and enrolled with the Division's Provider Enrollment Unit as a HLHC; (4) possesses a distinct HLHC provider number issued by the Division; (5) is subject to the fiscal, administrative, and clinical management of the hospital; and (6) provides services to members solely on an outpatient basis.

Hospital Outpatient Department - A department or unit located at the same site as the hospital's inpatient facility that operates under the hospital's license and provides services to members on an outpatient basis. Hospital outpatient departments include day surgery units, primary care clinics, and specialty clinics and E.D.s.

Level I Trauma Center - A hospital with a current Level I Certification of Verification from the American College of Surgeons (ACS).

MH/SAP Contractor - The entity with which the Division contracts to administer the Division's Mental Health and Substance Abuse Program (MH/SAP)

Managed Care Organization (MCO) – Any entity with which the Division contracts to provide

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primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) or that otherwise meets the state plan definition of an HMO.

Medicaid (also referred to as MassHealth) - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and the Waiver.

Mental Health/ Substance Abuse Program (MH/SAP) - A managed care program for the provision of mental health and substance abuse services to MassHealth members enrolled in the program.

Observation Services - Outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours. 130 CMR 410.414, Appendix G to the Division's Acute Outpatient Hospital Manual, the Division's billing instructions and the RFA contain payment rules regarding observation services.

Off-Site Radiation and Oncology Treatment Center - A hospital-owned or independently owned facility, not located at the site of the hospital's inpatient facility or hospital-licensed health center, that (1) provides radiation and oncology treatment; (2) is approved by and enrolled with the Division's Provider Enrollment Unit as an Off-Site Radiation and Oncology Treatment Center; (3) possesses a distinct provider number issued by the Division; (4) provides services to members solely on an outpatient basis; and (5) possesses appropriate DPH licensing for the provision of Radiation and Oncology Treatment.

Outpatient Services (also referred to as outpatient hospital services) – Medical services provided to a member in a hospital outpatient department or hospital-licensed health center. Such services include, but are not limited to, emergency services, primary care services, observation services provided in the hospital, ancillary services, day surgery services, and recovery room services. 130 CMR 410.414, Appendix G to the Division's Acute Outpatient Hospital Manual, the Division's billing instructions and the RFA contain payment rules regarding outpatient services

Outpatient Visit – An in-person encounter between an eligible member and a licensed practitioner (such as a physician, optician, optometrist, or dentist) or other medical professional under the direction of a licensed practitioner for the provision of outpatient services.

Pediatric Specialty Clinic - An outpatient specialty clinic (as approved by the Division) at a pediatric specialty hospital or at a hospital with pediatric specialty (inpatient) units, which provides specialty care to Medicaid members.

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Pediatric Specialty Hospital - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20, unless located in a facility already designated as a specialty hospital.

Primary Care - Primary care shall mean medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes but is not limited to physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention and referral when necessary. Primary care does not require the specialized resources of a hospital Emergency Department.

Primary Care Clinician Program (PCCP) - A comprehensive managed care program with primary care clinicians managing enrolled members' medical care.

Rate Year (RY) - The period beginning October 1 and ending September 30. RY00 begins on October 1, 1999 and ends on September 30, 2000.

Recipient (also referred to as member) - A person determined by the Division to be eligible for medical assistance under the MassHealth program.

School-Based Health Center (SBHC) Services - Health services provided to MassHealth members under the age of 21, a center located in a school setting which: 1) provides health services to MassHealth members under the age of 21; 2) operates under a hospital's license or is a hospital-licensed health center (HLHC); 3) meets the Division's requirements for reimbursement as an outpatient hospital or HLHC as provided at 130 CMR 410.401 et seq.; 4) is subject to a fiscal, administrative, and clinical management of an outpatient hospital or HLHC; 5) provides services to members solely on an outpatient basis; and 6) meets the Division's requirements in 130 CMR 450.170 through 130 CMR 450.174.

Significant Procedure Groups - A subset of Ambulatory Patient Groups consisting of most, but not all surgical procedures, other significant procedures, and other outpatient services that occur the day before, the day of, and the day after a significant procedure.

Site-of-Service List - Those services (including visits, treatments and procedures) that do not need to be provided in an outpatient department.

Trauma Team - A group of healthcare professionals organized to provide care in a Level 1 Trauma Center which satisfies the guidelines of "Qualifications of Trauma Care Personnel", as specified in the American College of Surgeons Committee on Trauma's "Resources for Optimal Care of the Injured Patient: 1993".

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Upper Limit - The term referring to the level below which it is determined that the hospital reimbursement methodology will result in payments for hospital services in the aggregate that are no more than the amount that would be paid under Medicare principles of reimbursement.

Urgent Care – Urgent care shall mean medical services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care is appropriately provided in a clinic, physician's office or in a hospital Emergency Department if a clinic or physician's office is inaccessible. Urgent care does not include emergent care and primary care.

Usual and Customary Charges - Routine fees that hospitals charge for outpatient services rendered to patients regardless of payer source.

Waiver - the Section 1115 Medicaid Research and Demonstration Waiver approved by the U.S. Department of Health and Human Services on April 24, 1995, and authorized by Chapter 203 of the Massachusetts Acts and Resolves of 1996.

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III: NON-COVERED SERVICES

The Division will reimburse Medicaid participating hospitals at the rates established in the RFA for all outpatient and emergency department services provided to Medicaid members except for the following:

A. Mental Health and Substance Abuse Services for Members Assigned to the MH/SAP

The MH/SAP contractor contracts with a provider network to deliver mental health and substance abuse services for Medicaid members assigned to the MH/SAP. Hospitals in the MH/SAP network are paid by the MH/SAP contractor for services to members assigned to the MH/SAP, pursuant to the contract between the MH/SAP contractor and each contracting hospital.

Hospitals that are not in the MH/SAP contractor's network (hereinafter "Non-Network Hospitals") do not qualify for Medicaid reimbursement for members assigned to the MH/SAP who are seeking mental health or substance abuse non-Emergent Care, except in accordance with a service specific agreement with the MH/SAP contractor. Non-Network Hospitals that provide medically necessary mental health and substance abuse Emergent Care to MH/SAP assigned members qualify for reimbursement by the MH/SAP contractor.

Hospitals are not entitled to any reimbursement from the Division, and may not claim such reimbursement for any services which are reimbursed by the MH/SAP contractor.

B. MCO Services

Hospitals providing services to Medicaid members enrolled in MCOs will be reimbursed by MCOs for those services.

Hospitals may not bill the Division, and the Division will not reimburse hospitals for services provided to Medicaid members enrolled in an MCO where such services are covered by the MCO's contract with the Division. Furthermore, hospitals may not "balance bill" the Division for any services covered by the MCO's contract with the Division. MCO reimbursement shall be considered payment in full for any MCO-covered services provided to Medicaid members enrolled in an MCO.

C. Air Ambulance Services

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

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D. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made exclusively pursuant to the contract and/or regulations governing the special program initiative.

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IV: REIMBURSEMENT SYSTEM

A. Outpatient Services

Rates for outpatient services covered under a contract between the acute hospital and the MH/SAP contractor that are provided to Medicaid patients eligible for or assigned to the Division's MH/SAP contractor shall be governed by terms agreed upon between the acute hospital and the MH/SAP contractor.

Hospitals will not be reimbursed on an outpatient basis when an inpatient admission to the same hospital, on the same date of service, occurs following provision of outpatient services. Reimbursement for such outpatient services will be provided through the acute hospital inpatient payment system only. See State Plan Attachment 4.19A.

The following methodology will apply to outpatient services when those services are rendered at hospital outpatient departments including emergency departments, hospital-licensed health centers (HLHCs), and school-based health centers (SBHCs). To be reimbursed for any services provided at a site other than the hospital outpatient department or SBHC, (including but not limited to HLHCs), the hospital must enroll that site with the Division as an appropriate provider type. If the Division does not recognize the site as a provider type, no service provided to a member at that site is reimbursable.

Hospitals will be reimbursed only for hospital services specified in Subchapter 6 of the Acute Outpatient Hospital Manual. Hospitals will be reimbursed for physician services specified in Subchapter 6 of the Acute Outpatient Hospital Manual and only in accordance with Section IV.A.1.

1. Physician Payments

- a. A hospital may only receive reimbursement for physician services provided by hospital-based physicians or hospital-based entities to Medicaid members. The hospital must claim payment in accordance with, and subject to 1) the Physician Regulations at 130 CMR 433.000 et seq., 2) the Acute Outpatient Hospital Regulations at 130 CMR 410.000 et seq.; and the payment rules as set forth in Section IV.
- b. Except as otherwise provided in Section IV.A.1.c below, such reimbursement shall be the lower of i) the fee in the most current promulgation of the DHCFP fees as established in

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114.3 CMR 16.00, 17.00 and 18.00; ii) the hospital's usual and customary charge for physician fees; or; iii) the hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than hospital-based physicians or hospital-based entities as defined in Section II.

- c. For physician services provided by a hospital-based physician or hospital-based entity for an outpatient service included on the site-of-service list, the hospital will be reimbursed at the lower of 1) 79% of the fee established in the DHCFP Regulations at 114.CMR 16.00, 17.00 and 18.00; 2) 100% of the hospital's usual and customary charge for physician fees; or 3) 100% of the hospital's actual charge submitted.
 - d. Hospitals will be reimbursed for physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the outpatient service(s) on the billed date(s) of service.
 - e. Physician services provided by residents and interns are not reimbursable separately.
 - f. Hospitals will not be reimbursed for physician services if those services are (1) provided by a community-based physician or community-based entity; or (2) are related to the provision of laboratory, ancillary, recovery room, off-site radiation and oncology treatment center, audiology dispensing, ambulance, psychiatric day treatment, and certain dental services as further described in Section IV.A below.
 - g. In order to qualify for reimbursement for physician services provided during the provision of observation services, the reasons for the observation services, the start and stop time of the observation services, and the name of the physician ordering the observation services, must be documented in the member's medical record.
 - h. When a hospital-based physician or hospital-based entity provides physician services during a radiology service, the hospital may, when the service is not reimbursed with a global fee that covers both technical and professional portions, be reimbursed for such physician services in accordance with Section IV.A.1.
2. Outpatient Hospital Department and Emergency Department Services Payment Limitations
- a. Payment Limitations on a Hospital Outpatient and Emergency Department Services Preceding an Admission

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Hospitals will not be separately reimbursed for hospital outpatient department or emergency department services when an inpatient admission to the same hospital, on the same date of service, occurs following the hospital outpatient department or emergency department visit; provided, however, that this payment limitation does not apply where an admission involving a one day length of stay occurs on the same day following a significant procedure. ■

b. Payment Limitations on Emergency Department Services

Hospitals will not be reimbursed for Emergency Department services, if such services are for: (i) primary care services provided to any member; (ii) urgent care services provided to a member enrolled in the PCCP, in an emergency room between 8:00 A.M. and 9:59 P.M., unless so authorized by the member's PCC or unless the member's PCC is not available for authorization; and, (iii) urgent care services provided in an E.D. to a member not enrolled in the PCCP, when the hospital determines that the member has the opportunity to receive urgent care elsewhere (e.g. the member's regular physician, an accessible Community Health Center, or the hospital's outpatient clinic).

All members presenting in the emergency department must be screened in the emergency department in accordance with 42 U.S.C. 1396dd et seq. Hospitals will be reimbursed for such screening services either through a) the appropriate APG payment, or b) through the Emergency Department Screening Fee (see Section IV.A.4), whichever is applicable.

3. Ambulatory Patient Groups

For outpatient hospital services provided in a hospital or Hospital Licensed Health Center on or after July 1, 1999, hospitals will be paid under the Ambulatory Patient Group (APG) system. For a particular provision of services, the hospital will be paid a flat rate that depends on the procedures performed and the patient's diagnoses. For individual services that require extraordinary use of resources, hospitals may be able to receive outlier payments.

a. Scope

As defined by the Division [and outlined in detail in Exhibit A to Attachment 4.19B(1)], APGs consist of 290 groups of outpatient services and procedures, categorized based on CPT and HCPCS Level II codes, that are covered by the Division, as well as local procedure codes

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established by the Division. The codes that comprise each APG are consistent with the latest available update of 3M Health Information Systems' Ambulatory Patient Grouper, Version 2.0, as modified by the Division.

b. APG Rate Development

The rate for each APG is the product of each APG's relative weight, and a conversion factor, defined as follows.

1. *Relative Weights*: APG weights were set from all paid MassHealth in-state acute outpatient hospital and Hospital Licensed Health Center claims for hospital rate year 1996 (October 1, 1995 to September 30, 1996). The claims were bundled into each APG. Each APG's weight was calculated using MassHealth data, such that it reflects the experience of Massachusetts hospitals in service MassHealth members. For each APG, the relative weight is the quotient of:

$$\frac{\text{Average Estimated hospital cost for all visits for the APG}}{\text{Average Estimated hospital cost for all visits}}$$

Weights were set based on an untrimmed paid claims data from the 1996 rate year. Medicare crossover claims were excluded from the calculation. Costs were estimated by multiplying submitted charges by hospital-specific cost to charge ratios.

2. *Conversion Factors*: The Baseline Conversion Factor is the average rate year 1996 MassHealth outpatient payment per visit, multiplied by an outlier adjustment factor of 95%, a coding refinement factor of 97%, a 95% efficiency discount, and a 99.5% adjustment for PCC enhancement fees. The conversion factor was multiplied by 2.38% to reflect price changes between FY96 and FY97, by 2.14% to reflect price changes between FY97 and FY98, by 1.9% to reflect price changes between FY98 and FY99, and by 1.43% to reflect price changes between FY99 and FY00. The baseline conversion factor was multiplied by 1.12 to further adjust for the consolidation, packaging and discounting which occurs in the APG reimbursement methodology.

Based upon the MassHealth service mix index, derived from the sum of APG relative weights taken from a seven week sampling of paid FY1999 claims, hospitals were ranked from highest to lowest in terms of net

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revenue change under the APG methodology. The baseline factor was multiplied by 1.10 for the top ten (10) hospitals with an estimated loss of \$50,000 or more, yielding a Transitional Conversion Factor of \$ 120.47. The baseline factor was multiplied by 0.95 to arrive at a Standard Conversion factor of \$ 104.05, which applies to all other hospitals and any new providers.

c. APG Categories:

APGs are categorized into five distinct categories. These categories are used as part of the payment methodology:

1. *Significant Procedure APGs:* Includes the following APGs: 001-055, 071-083, 093-138, 151-192, 194-250, 253-255, 281
2. *Therapy APGs:* Includes the following APGs: 057, 084, 091, 092, 139, 140, 193, 251, 252, 271-273, 282-289
3. *Medical APGs:* Includes APGs 431 through 721.
4. *Ancillary APGs:* Includes APGs 301 through 422.
5. *Error APGs:* Includes APGs 992-999. These APGs include coding errors and ungroupable claims, and are therefore not payable under the APG system.

d. Significant procedure APGs:

1. A three-day period called a "window" is used to determine payment of Significant Procedure APGs. This window includes the day of, the day before, and the day after the occurrence of a service assigned a Significant Procedure APG.
2. No separate payment is made for any Medical or Ancillary APGs occurring during the three-day window, except as provided below for chemotherapy drug APGs.

e. Multiple APGs:

A single visit may have more than one APG assigned. Payment for a single visit with multiple APGs is as follows:

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1. *Significant Procedure APGs:*

- a. When more than one significant procedure APG is assigned during a three-day window, the significant procedure APG with the highest relative weight is paid at 100%, with the exception of chemotherapy drug APGs (APGs 391-395), which are paid at 100%.
- b. Additional significant procedures are either paid at 50% of the APG rate ('discounted'), or are 'consolidated'. Consolidated APGs are assigned when a simple procedure is an integral part of a more complex procedure. Payment for the simple procedure is consolidated into the payment for the more complex procedure, and no separate payment is made for the simple procedure.
- c. If a Significant Procedure APG and a Therapy APG are assigned during the three-day window, the highest weighted Significant Procedure or Therapy APG is paid at 100% and any additional APGs are paid at 50%.

No separate payment is made for any Medical and/or Ancillary APGs occurring during the three-day window, with the exception of chemotherapy drug APGs (APGs 391-395), which are paid at 100%.

2. *Therapy APGs*

When more than one Therapy APG is assigned, the highest weighted Therapy APG is paid at 100%, and additional Therapy APGs are discounted and paid at 50%. No separate payment is made for additional Medical and/or Ancillary APGs, with the exception of chemotherapy drug APGs (APGs 391-395), which are paid at 100%.

3. *Medical APGs*

When more than one Medical APG is assigned, the Medical APG with the highest weight is paid at 100%. No separate payment is made for additional Medical and/or Ancillary APGs.

4. *Ancillary Visits*

When more than one ancillary APG is assigned, the Ancillary APG with

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the highest weight is paid at 100%. Additional Ancillary APGs are discounted and paid at 50%.

f. Outlier Payments:

A visit or visits within a three day window for a Significant Procedure may qualify for outlier payments if the difference between the APG payment and 45% of the hospital's charges exceed the "outlier threshold" of \$1450.00. The APG payment in such circumstances is the sum of all payments for all APGs assigned for that visit. The outlier payment will equal the difference of the estimated hospital cost and the APG payment. The estimated hospital cost is the product of the billed charges and the hospital-specific cost-to-charge ratio. The hospital-specific cost-to-charge ratio was derived by taking total ancillary costs including capital from the FY93 RSC-403 and by dividing by the total ancillary revenues from the FY93 RSC-403.

4. Emergency Department Screening Fee

The following Emergency Department Screening fee payments are excluded from the APG methodology. Hospitals will be separately reimbursed for emergency department screening as follows:

a. Conditions of Reimbursement

Hospitals will be reimbursed a separate screening fee only when a hospital-based physician or a physician providing services on behalf of a hospital-based entity provides screening services to a MassHealth member in a hospital Emergency Department as follows:

- i. the Emergency Department physician determines at any hour that a member requires elective or primary care;
- ii. the Emergency Department physician determines between the hours of 8:00 a.m. and 9:59 p.m. that a member enrolled in the Division's PCCP requires urgent care and the PCC declines to authorize emergency room services; or
- iii. the Emergency Department physician determines that a member not enrolled in the Division's PCCP requires urgent care, and the hospital determines that the member has the opportunity to receive this care

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elsewhere.

b. Rate Methodology

The Emergency Department Screening Fee is based on the average cost per screening visit and the rate for a comprehensive physician's office visit. The bundled rate includes components for professional services, ancillary services required to determine the acuity of the patient's condition, educational instruction on the use of the Division's PCC/managed care system for members enrolled in the PCCP, educational instruction on accessing primary care/urgent services in community health centers, hospital outpatient clinics, and physicians for members not enrolled in the PCCP, related educational materials and administrative duties. The Emergency Department Screening Fee is the exclusive reimbursement for services provided under the circumstances set forth in Section IV.A.4.a.

No additional reimbursement, including but not limited to, ancillary services, professional services, and Emergency Department visit payments applies

5. **The Norplant System**

a. Payment for Norplant Services

Hospitals will be reimbursed according to both the Physician Regulations in 130 CMR 433.000 and the fees established in the most recent promulgation of the DHCFP's Family Planning Regulations (114.3 CMR 12.00), when a hospital-based physician or a physician on behalf of a hospital-based entity inserts, removes, or removes and reinserts the Norplant System of Contraception. The hospital may only bill for the hospital-based physician payment as the fee (according to the DHCFP's Family Planning Regulations at 144.3 CMR 12.00) represents payment in full for all services associated with the Norplant System of Contraception.

b. Physician Payment

Hospitals will be reimbursed for hospital-based physicians or hospital-based entities as set forth in Section IV.A.1 above.

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6. Off-Site Radiation and Oncology Treatment Centers

Hospitals that provide radiation and oncology treatment services through an Off-Site Radiation and Oncology Treatment Center will be reimbursed according to the lower of the fee schedule or the hospital's usual and customary charge. Only those services listed by the Division are reimbursable at the Off-Site Radiation and Oncology Treatment Center. These rates represent payment in full for services and neither the hospital or physician is entitled to any additional reimbursement (e.g., hospital outpatient department visit payments, APGs, physician payments).

To be reimbursed for any services provided at an Off-Site Radiation and Oncology Treatment Center, the hospital must enroll that site with the Division as a provider. If the Division does not recognize the site as an Off-Site radiation and Oncology Treatment Center provider, no service provided to a member at that site is reimbursable.

7. Audiology Dispensing

a. Payment for Audiology Dispensing Services

Hospitals will be reimbursed for the dispensing of hearing aids only by a hospital-based audiologist according to the audiologist regulations at 130 CMR 426.00 et seq., and at the lower of the most current of the DHCFP fees as established in 114.3 CMR 23.00, or the hospital's usual and customary charge.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of audiology dispensing services.

8. Ambulance Services

a. Payment for Ambulance Services

Ambulance services shall be classified as either air or ground ambulance services. Ground ambulance services shall be reimbursed by the Division subject to all regulations pursuant to 130 CMR 407.000 et seq., in the

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Transportation Manual. Payment shall be the lower of the rates established by the DHCFP, under 114.3 CMR 27.00, et seq., or the hospital's usual and customary charge.

If the costs of ground ambulance services were included by the hospital in the FY90 cost base for FY90 outpatient department services, no additional reimbursement for ground service ambulance may be billed.

In order to receive reimbursement for air ambulance services, providers must have separate contracts with the Division for such services.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of ambulance services.

9. Psychiatric Day Treatment Program

a. Payment for Psychiatric Day Treatment Services

For services to members who are not enrolled in the MH/SAP, the Division will reimburse acute hospital outpatient department psychiatric day treatment programs which are enrolled with the Division as such according to the regulations as set forth in the Psychiatric Day Treatment Program regulations at 130 CMR 417.401 - 440, at the lower of rates promulgated by the DHCFP, as established in 114.3 CMR 7.03, or the hospital's usual and customary charge.

Hospitals may not bill for psychiatric day treatment services in addition to outpatient clinic mental health services if both were delivered on the same day.

In order to qualify for reimbursement, Psychiatric Day Treatment Programs must be certified by the Division as described in 130 CMR 417.405.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of Psychiatric Day Treatment Program services.

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10. Dental Services

a. Payment for Dental Services

All covered dental services will be reimbursed by the Division, subject to all regulations at 130 CMR 420.000 et seq., in the Dental Manual, at the lower of the most current rates promulgated by the DHCFP, as established in 114.3 CMR 14.00 et seq., or the hospital's usual and customary charge, except when the conditions in 130 CMR 420.429(A) or (D) apply. When these conditions apply, the Division will reimburse the hospital according to Section IV.A.3.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of dental services, except when the conditions in 130 CMR 420.429(A) or (D) apply. Under those circumstances, in addition to the APG payment under Section IV.A.3, when a hospital-based physician or hospital-based entity provides physician services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

11. Adult Day Health

a. Payment for Adult Day Health Services

The Division will reimburse acute hospital outpatient departments as set forth in the Adult Day Health regulations at 130 CMR 404.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 10.00 et seq., or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Adult Day Health service payment, when a hospital-based physician or a hospital-based entity provides physician services during Adult Day Health Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

12. Early Intervention Program

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a. Payment for Early Intervention Services

The Division will reimburse acute hospital outpatient departments as set forth in the Early Intervention Program regulations at 130 CMR 440.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 49.00 et seq., or the hospital's usual and customary charge. •

b. Physician Payment

In addition to the Early Intervention Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Early Intervention Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

13. Home Health

a. Payment for Home Health Services

The Division will reimburse acute hospital outpatient departments as set forth in the Home Health Agency regulations at 130 CMR 403.401-441, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 3.00 or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Home Health Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Home Health Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

14. Adult Foster Care

a. Payment for Adult Foster Care

The Division will reimburse acute hospital outpatient departments for Adult Foster Care services at the lower of the rates certified by the Office of Purchased

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Services in the Executive Office of Administration and Finance and as set forth in the **Adult Foster Care Guidelines**, or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Adult Foster Care Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Adult Foster Care Services, the hospital may be reimbursed for such physician services, in accordance with Section IV.A.1.

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B. Reimbursement for Unique Circumstances
Non-Profit Acute Teaching Hospitals Affiliated with a State-Owned University Medical School

- a. Subject to section IV.C.2.b, the payment amount for outpatient, emergency department, and hospital-licensed health center services at non-profit acute care teaching hospitals affiliated with a state-owned university medical school shall be as follows. The data used for this payment will be from the most recent submission of the hospitals' or predecessor hospitals' DHCFP-403 report(s).

The hospital's total outpatient charges are multiplied by the hospital's overall outpatient cost to charge ratio (the hospital's outpatient cost to charge ratio is calculated using the DHCFP-403 total outpatient costs located on schedule II, column 10, line 114 as the numerator and total outpatient charges located on schedule II, column 11, line 114 as the denominator) in order to compute the total outpatient costs. The total outpatient costs are then multiplied by the Medicaid outpatient utilization factor (this factor is calculated by dividing the total Medicaid outpatient charges by the total hospital outpatient charges) in order to calculate Medicaid outpatient costs. Medicaid outpatient costs are then multiplied by the inflation rates for those years between the year of the cost report and the current rate year.

- b. Any payment amount in excess of amounts which would otherwise be due any non-profit teaching hospital affiliated with a state-owned university medical school pursuant to sections IV.A and IV.B is subject to specific legislative appropriation and intergovernmental funds transfer.

C. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA). If any portion of the reimbursement methodology is not approved by HCFA, the Division may recover any payment made to a hospital in excess of the approved methodology.

D. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

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E. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining hospitals' rates. Such rates may, in the Division's sole discretion, affect computation of any of the efficiency standards applied to outpatient costs.

F. Hospital Change of Ownership

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the hospital during the effective period of the RFA, the Division, in its sole discretion, shall determine, on a case by case basis (1) whether the hospital qualifies for reimbursement under the RFA, and, if so, (2) the appropriate rate of such reimbursement. The Division's determination shall be based on the totality of the circumstances. Any such rate may, in the Division's sole discretion, affect computation of any of the efficiency standards applied to outpatient costs.